# SCDHHS AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Record #: _____ Client SS #: _____

I _____ hereby authorize
*(Client or Personal Representative)*

_____ to disclose specific health information
*(Name of Provider/Plan/Agency)*

from the records of the above named client to: _____
*(Recipient Name/Address/Phone/Fax)*

_____

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I further understand that I may request a copy of this signed authorization.

| _____ | _____ | _____ |
|---|---|---|
| *(Signature of Client)* | *(Date)* | *(Witness-If Required)* |
| _____ | _____ | _____ |
| *(Signature of Personal Representative)* | *(Date)* | *(Personal Representative Relationship/Authority)* |

**********

| *NOTE: This Authorization was revoked on* _____ | _____ |
|---|---|
| *(Date)* | *(Signature of Staff)* |

## REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
*(Name of Client)*

signed by_____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
*(Date)*

rescinded date is legal and binding.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| *(Signature of Client)* | *(Date)* | *(Signature of Witness)* | *(Date)* |

| _____ | _____ | _____ |
|---|---|---|
| *(Signature of Personal Representative)* | *(Date)* | *(Personal Representative Relationship/Authority)* |

## VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
*(Name of Client or Personal Representative)*

on _____. The client or his personal representative has been informed that any
*(Date)*

action taken on this authorization prior to the rescinded date is legal and binding.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| *(Signature of Staff)* | *(Date)* | *(Signature of Witness)* | *(Date)* |